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Satisfaction with therapist-delivered vs. self-administered online cognitive behavioural treatments for depression symptoms in college students

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Participants with symptoms of depression received either eight sessions of therapist-delivered email cognitive behaviour therapy (eCBT; $n = 37$), or eight sessions of computerised CBT self-administered treatment (cCBT; $n = 43$). At post-treatment participants completed a questionnaire to determine what they found satisfying about their online treatment. Quantitative and qualitative analysis was employed to report outcomes. A sample of 25 participants(eCBT $n = 10$; cCBT $n = 15$) completed the satisfaction questionnaire. Both groups were satisfied with accessing and using an online treatment and that they had self-control over their treatment. Perceived anonymity was important for the eCBT group. For the cCBT group they found the treatment user-friendly, engaging and also a source of learning. Both groups disliked that the online treatment could at times be complicated and impersonal.

Keywords: online treatments for depression; satisfaction with treatment; depression; qualitative analysis

The current study sought to examine participants' satisfaction with therapist-delivered and self-administered online cognitive behavioural treatments for depression. Depression displays high rates of lifetime incidence, early age onset, high chronicity and role impairment (Richards, 2011). Depression, in particular, is a growing problem for third-level students, with elevated levels being reported (Royal College of Psychiatrists, 2003). In recent years university mental health services have met with increasing demands and greater severity of presentations of mental health difficulties (Mowbray et al., 2006; Rana, Smith, & Wlaking, 1999).

Evidence-based treatments such as cognitive behavioural therapy (CBT) are established options for the treatment of depression (Hollon & DeRubeis, 2006). However, there are many barriers to accessing treatment, including a shortage of trained professionals, waiting lists, costs, and personal barriers such as stigma. Consequently, many people with depression do not receive treatment (Kohn, Saxena, Levav, & Saraceno, 2004). Research on computerised cognitive behaviour therapy (cCBT) for depression has demonstrated its efficacy (Andersson & Cuijpers, 2009; Richards & Richardson, 2012). The development and delivery of CBT treatment

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programs online is one attempt to overcome barriers to access and to meet the growing demands that university mental health services presently face.

Several online treatments for depression studies have included satisfaction measures for clients. Satisfaction reports provide knowledge about how clients experienced computer-based interventions (Proudfoot, 2004; Wright et al., 2005). Data gathered from satisfaction reports can aid in understanding what elements of the delivery of cCBT are most welcome and what elements or aspects can be enhanced upon. The different studies used quantitative methodology asking participants to rate their level of satisfaction (Cavanagh, Seccombe, & Lidbetter, 2011; Learmonth & Rai, 2008; Meyer et al., 2009; Whitfield, Hinshelwood, Pashely, Campsie, & Williams, 2006) or qualitative methodology soliciting participants' opinions on what were considered helpful and unhelpful aspects of treatment (Meyer et al., 2009; Perini, Titov, & Andrews, 2009; Topolovec-Vranic et al., 2010). Some of the studies (Cavanagh et al., 2011; Learmonth & Rai, 2008) looked specifically at Beating the Blues™, the program used in the current study. The studies usually reported high satisfaction and that participants found the programs useful, relevant, easy to use and helpful, that the online treatments benefitted them, and that the online treatments met or exceeded their expectations (Learmonth & Rai, 2008; Meyer et al., 2009; Perini et al., 2009; Whitfield et al., 2006). Other helpful aspects reported were that such programs are preferred over, for example, a workbook, that they improved participants' mood and on occasion the program equalled or was better than a 'real' therapist (Meyer et al., 2009; Whitfield et al., 2006). Additionally, online treatments that included therapist support reported that the quality of the communication with the therapist was excellent or good (Perini et al., 2009). However, difficult aspects were also highlighted, for instance some participants found their online treatment demanding and perhaps more geared towards a younger age group (Topolovec-Vranic et al., 2010).

The National Institute for Health and Clinical Excellence (2006) has recommended the self-administered Beating the Blues™ program (Proudfoot, 2004) as a treatment option for people with mild or moderate depression. The current study regarding participant satisfaction with online treatment for depression was one part of a parallel group controlled trial that examined two modes of delivering the Beating the Blues™ program for depression treatment within a university setting, one self-administered computerised CBT (cCBT) and the other therapist-delivered email CBT (eCBT) (Richards, Timulak, & Hevey, in press). For the main study we were interested, firstly, in establishing whether different modes of delivering the same CBT protocol could be effective. We were interested, secondly, in investigating therapist factors through an assessment of the levels of working alliance in both groups and, thirdly, whether alliance could predict depression outcomes at post-treatment. We hypothesised that both treatment conditions would be effective, but that the therapist-supported eCBT would demonstrate greater improvement. Additionally, we wanted to determine participants' attitudes towards their treatment. The study thus sought to address the following research question: were participants satisfied with the treatment and especially its mode of delivery online?

To contextualise the results from the satisfaction measure, the reader will know that the outcomes from the main trial reported that participants in both treatment groups displayed significant statistical and clinical improvement in depressive symptoms as reported on the Beck Depression Inventory (BDI-II) and this was maintained at six-month follow-up. Additionally, there existed a non-significant trend for better outcomes in the eCBT group (Richards et al., in press).

Method

Design

Quantitative analysis, using descriptive statistics, of users' agreement with items associated with their access and use of an online treatment was undertaken, including how helpful participants found the online treatment. Chi-square comparisons of responses were used to compare any differences between the two treatment groups. A qualitative descriptive-interpretative analysis (Elliott & Timulak, 2005) was adopted to analyse the content reported by clients regarding what they most liked and least liked about the online treatment.

Participants

Registered students at an Irish university with depressive symptoms within the mild to moderate range (14 to 29) as established by the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996) were included in the comparison trial. Others with minimal (<14) or severe (>29) symptoms were excluded from participating in the trial and were offered other appropriate support. Participants were randomised to one or other of the available treatment conditions and randomisation was carried out independent of the researchers. Thirty-seven ($n=37$) participants began treatment in the therapist-delivered asynchronous email CBT group (eCBT). The group was composed of 26 females (70%) and 11 males (30%), and their age range was 19–59 years ($M=25.65$). Forty-three ($n=43$) participants began treatment in the computerised CBT self-administered treatment group (cCBT). The group was composed of 25 females (58%) and 18 males (42%), and their age range was 20–50 years ($M=26.53$). The results of the main study regarding the effectiveness of the treatments are reported elsewhere (Richards et al., in press).

Instruments

Satisfaction with Online Treatment (SAT)

At post-treatment (week 8), participants were asked to complete a satisfaction with treatment measure. The measure was developed with the primary aim of determining participants' attitudes towards their online delivered treatment. The first part contained four questions that assessed how strongly or not participants agreed to use of the computer to access treatment, how easy they found the online treatment to use, whether they felt that the treatment they received would have a lasting effect for them and whether they would specifically recommend online treatment to others. Responses to each question were anchored from 'Agree very strongly', 'Agree strongly', 'Neither agree nor disagree', 'Disagree strongly', to 'Disagree very strongly'. Secondly, participants were asked how helpful they found the online treatment. Participants' responses were anchored from 'Very helpful', 'Quite helpful', 'Not really helpful', to 'Not at all helpful'. Lastly, the measure also contained two qualitative questions that asked participants to describe what they most liked and least liked about the online treatment.

Beck Depression Inventory

The Beck Depression Inventory (BDI-II; Beck et al., 1996) was employed to assess depression symptoms. It was used at baseline, at the end of treatment and also at

follow-up. The BDI is a common and frequently used questionnaire. The content of the BDI-II reflects the diagnostic criteria outlined in the DSM-IV for major depressive disorders. The BDI for the study sample demonstrated high reliability (Cronbach's $\alpha = .88$).

Procedure

On meeting the established eligibility criteria for the comparison trial, participants were randomly assigned to either self-administered computerised cognitive behavioural therapy (cCBT) or therapist-delivered asynchronous email cognitive behavioural therapy (eCBT).

Self-administered computerised CBT (cCBT)

Beating the Blues™ is a well-established online self-administered treatment for depression and anxiety. Research studies of the self-administered program have generally included five minutes of contact pre- and post-session support for users. This support has been delivered by a clinical helper, nurses, administrative staff or psychological assistants (Richards & Richardson, 2012). In the self-administered computerised CBT condition for the current study the Beating the Blues™ program was delivered without support.

During the eight sessions of Beating the Blues™ users identified specific problems and realistic treatment goals. The program included cognitive modules that focused on identifying and challenging automatic thoughts, thinking errors, core beliefs and attributional styles. The program included problem-directed behavioural components including activities such as scheduling, problem solving, graded exposure and sleep management. Action planning and relapse prevention were also included. Beating the Blues™ uses interactive modules, animations and voice-overs and a key feature is a series of filmed case studies of fictional patients who model the symptoms of depression and help to demonstrate the treatment by cognitive behavioural therapy.

Therapist-delivered email CBT (eCBT)

In the therapist-delivered condition the Beating the Blues™ program was delivered with support from a therapist. Participants were consecutively assigned to two therapists. They each received a text version of the Beating the Blues™ protocol (in email format where all multimedia elements such as the filmed case studies were delivered in text). Participants also had the opportunity to write in free-text about issues that concerned them. This was additional to the prescribed CBT (Beating the Blues™) framework. The reply from the counsellor included a response to their free-text alongside the specific CBT content for each session. The therapists used generic counselling skills in responding to the free-text part through (1) showing empathy and acknowledgement of emotions, (2) provision of guidance and information, (3) validation of successes, (4) promotion of self-care and social support, and (5) building alliance. The responsive use of generic counselling skills in the therapist's responses was a part of the therapist-delivered condition and adherence to it was assessed by independent raters and considered to be adequate (see the main study Richards et al., in press).

Therapists

Two counsellors working at the university counselling service delivered the eCBT condition. Both had specialist training in online counselling and their experience in online counselling was between 1.5 and 3 years.

Data analysis

Descriptive statistics established the percentage of users' agreement with items associated with their access and use of an online treatment, including how helpful the participants found the online treatment. Chi-square comparisons of responses were used to compare the levels of satisfaction between the treatment groups. T-tests were employed to determine any differences in the characteristics described for the group that completed the satisfaction measure ($n = 25$) and the remainder of those in the treatment ($n = 55$).

The descriptive and interpretive qualitative analysis outlined by Elliott and Timulak (2005) was adopted to analyse the qualitative content reported by clients regarding what they most liked and least liked about the online treatment. The approach involved firstly delineating meaning units, defined by Elliott and Timulak (2005) as the smallest units conveying the essential meaning when out of their context. These were then organised into suitably named categories that captured any similarities and differences among them. The analysis was first performed by the first author and then audited by the second author who was not aware from which condition (eCBT or cCBT) the data came.

Results

Of the 80 participants who began treatment ($n = 37$ in eCBT and $n = 43$ in cCBT), 25 (eCBT: 10; cCBT: 15) completed the satisfaction measure. This represented a global response rate of 31% (eCBT: 27%; cCBT: 35%). The treatment was eight sessions and the number completed for each group in total was 3.97 ($SD = 2.2$) for eCBT and 4.05 ($SD = 2.9$) for cCBT. For the participants who completed the satisfaction measure, the mean number of sessions completed was 5.64 ($SD = 2.2$), and for each group was 5.10 ($SD = 2.2$) for eCBT and 6.00 ($SD = 2.2$) for cCBT. Levels of depression symptoms were the same in both groups at baseline: $M = 22$ ($SD = 4.7$). At post-treatment depressive symptoms were $M = 8.70$ ($SD = 4.7$) for the eCBT group and $M = 13.50$ ($SD = 6.7$) for the cCBT group. Seven males and three females responded to the satisfaction measure from the eCBT group and from the cCBT group seven females and eight males responded. The age range in the eCBT group was 19–59 ($M = 28$; $SD = 12.4$) and in the cCBT group was 21–50 ($M = 29$; $SD = 7.7$). The numbers of sessions completed by the respondents were as follows. Two completed fewer than four sessions, five completed four or more sessions, and three completed all eight sessions for the eCBT group. For the cCBT group, four completed fewer than four sessions, four completed four or more sessions, and seven completed all eight sessions.

T-tests were conducted to determine any differences in the characteristics described for the group ($n = 25$) that completed the SAT measure and the remainder of the main group ($n = 55$) of participants who began treatment. These analysis were also conducted for each of the treatment groups separately (eCBT: $n = 27$ and cCBT:

n = 28) compared to the remainder of the group ($n = 55$) of participants who began treatment in each condition.

The results demonstrated that there was a significant difference between the groups on the number of sessions completed $t(78) = -4.18$, $p = .000$. The 25 who completed SAT forms averaged $M = 5.64$ (*S.D.* = 2.40) sessions compared to the 55 who did not complete SAT forms averaging $M = 3.27$ (*S.D.* = 2.19) sessions. The results for sessions completed were equal between the sub-groups eCBT $t(35) = -2.00$, $p = .035$ and cCBT $t(41) = -3.66$, $p = .001$ compared to their equivalents in the main treatment group. The groups did not differ on baseline or post-treatment depression scores. Age was significantly greater ($M = 28.64$, *S.D.* = 9.64) in the group that returned SAT forms compared to the others in the treatment ($M = 24.98$, *S.D.* = 4.49); however, further analysis of the sub-groups revealed age to be signigicant only for the cCBT group ($M = 29.07$, *S.D.* = 7.74) in comparison to their equivalents ($M = 25.18$, *S.D.* = 4.18) in the entire treatment group $t(41) = -2.14$, $p = .038$. Chi-Square revealed no differences in gender between the two groups $\chi^2(1; N = 80) = .945$, $p > .05$. It can be concluded that except for the greater number of sessions completed by both groups and the significant difference in age for the cCBT group, the group that completed SAT are largely representative of the group that began treatment.

Participants were asked to rate how strongly or not they agreed to use of the computer to access treatment, how easy they found the online treatment to use, whether they felt that the treatment they received would have a lasting effect for them and whether they would specifically recommend online treatment to others. Table 1 displays the results from the quantitative analysis of users' agreement with these items. Chi-square comparisons of responses revealed that no significant differences were found between the groups and their responses for each of the questions. However, Cramer's V statistic showed a non-significant trend for the cCBT group that they found the treatment easy to use and that they felt the treatment would have lasting effects, more so than eCBT.

The satisfaction measure also asked how helpful the participants found the online treatment. The majority of participants in both groups (eCBT: 90%; cCBT: 87%) found the online treatment helpful. Chi-square comparisons of any differences in response between the groups were not significant ($\chi^2(1; N = 25) = .079$, $p > .05$).

The final two questions in the satisfaction measure were qualitative and asked participants what they most liked and least liked about the online treatment. Both groups reported that they liked having self-control over the administration of the treatment program. Thereafter, the eCBT group identified anonymity as something most liked. The cCBT group reported that the treatment was engaging and user-friendly; these were less so for the eCBT group. Lastly, the cCBT group identified that they liked the range of CBT techniques and strategies that the treatment program offered.

Qualitative analysis also reported on what participants least liked about the online treatment. Both groups reported that the treatment could be complicated and impersonal and involved a lot of work. The eCBT group reported that something they least liked was the lack of deadlines. The cCBT group identified more items that they disliked than did the eCBT group, and these included that the treatment at times did not match the needs of the user, technical difficulties in using the program, and that the format of delivery could be irritating.

Table 1. Results from the satisfaction measure questions.

	eCBT, $n = 10$			cCBT, $n = 15$			
	Agree	Disagree	Neither	Agree	Disagree	Neither	Comparisons between the groups' responses (Chi Square)
I was happy to use the computer to access treatment	60%		40%	73%		27%	$\chi^2(2; N = 25) = .962, p > .05$
I found the online treatment easy to use	50%	20%	30%	87%		13%	$\chi^2(3; N = 25) = 5.42, p > .05$
I feel the treatment received will have a lasting effect	40%	10%	50%	47%	10%	43%	$\chi^2(4; N = 25) = 3.82, p > .05$
I would recommend the online treatments to others	60%		40%	60%	7%	33%	$\chi^2(3; N = 25) = .785, p > .05$

Note. Neither = neither agree nor disagree; eCBT = therapist-delivered asynchronous email CBT counselling; cCBT = computerised CBT self-administered treatment.

Discussion

The study established that a standard self-administered cCBT protocol program can also be successfully delivered online as a therapist-delivered asynchronous mode (Richards et al., in press). The relative merits of the different modes of delivery are discussed below. The results from the satisfaction measure are encouraging and demonstrate broadly that participants in both delivery modes, who provided the data, were satisfied with the treatment and found it to be helpful for them. Participants who completed SAT forms completed more sessions than the remainder of the group who began treatment and for the cCBT group participants who completed the SAT form were older than their counterparts in the entire cCBT treatment group.

The majority were satisfied to be able to access treatments online and this is encouraging as it also supports the general use of technology in students' lives (Demunter, 2005) and the potential to realise the benefits of using technology to increase access to treatment. The population were self-referred and this seems to increase the likelihood of users reporting satisfaction with online delivery of psychological interventions (Mataix-Cols, Cameron, Gega, Kenwright, & Marks, 2006). This may also contribute to the fact that the majority of participants found it easy to use, as perhaps they were comfortable with their computer literacy prior to electing to participate. These are important elements for whichever mode of delivery is employed.

The agreement about comfort and ease of use is possibly higher in the cCBT group than in the eCBT group. However, this is preliminary as it is based on very small numbers. It is certainly the case for the eCBT group that an email containing a lot of text could have been cumbersome and potentially reduce ease of use. This might explain why some of the standard CBT elements, such as relaxation techniques and distraction techniques, were not much responded to by participants in the eCBT condition. Carlbring (2004) suggests that contact purely via email is perhaps not powerful enough to stimulate the maintenance of treatment. While a successful therapist-delivered CBT condition can realise equal benefits to self-administered cCBT, its utility in our study may be hampered by the mode of delivery – in this case asynchronous and text-based – which did not allow for certain interactive elements of the Beating the Blues program, such as the short video clips of people demonstrating depression and its treatment. However, in general it is the case that computer-based supported treatments yield greater effects than unsupported treatments (Richards & Richardson, 2012).

The lowest-rated item in the satisfaction measure was whether participants considered the treatment would have a lasting effect. It seems that participants who provided the data were not confident about any lasting effects that the treatment could have for them. A trend favouring the cCBT group possibly exists, suggesting they were more positive about any lasting effects. However, in support of lasting effects, the main study reported that outcomes from both delivery modes were maintained at six-months follow-up (Richards et al., in press).

Participants' satisfaction with the online treatment disposed them favourably to recommending the treatment to others. Only in the cCBT condition was there a small percentage that disagreed. The response corresponds to the outcome that almost 90% in both groups, of those that returned data, agreed that the online treatment was

helpful. The satisfaction data clearly show that both delivery modes were acceptable and could be recommended as viable treatments for university students.

The data collected from the qualitative questions consolidate the satisfaction reports. Participants in both groups identifed self-control over the administration of the program as something they liked about the program and potentially contributed to the high rates of helpfulness and satisfaction. As one cCBT user wrote: 'I could go at my own pace. I could fit it around my schedule and access it when it suited me'. This clearly places the control and direction of treatment in the hands of the user, a potentially empowering action. This is a noted benefit of online and remote delivery in general (Ritterband et al., 2003). Such a benefit seems to be an important element in online-delivered treatments; participants may be attracted to this form of delivery over and above more traditional modes. Perhaps some users needed to feel this sense of controlling the pace and direction of their treatment so as to benefit. It might also give users the necessary flexibility to avail themselves of treatments in the context of other demands in their lives such as work and study. Users' (eCBT) comments are supportive: 'No stress. You could open your post when you liked and had time. You could read and reread the sessions'. And another: 'It gave me time to think about what I was saying. I'd fill each session in over days so I'd always be thinking about them and what to write'.

Both groups identifed how the treatment was well structured and gave them a sense of purpose and learning. One eCBT user wrote how they 'felt that each session had a purpose and an end product, be it a completed worksheet or an exercise'. Another cCBT user wrote how the program 'gave a sense of purpose and learning'. It seems that the treatment program was focused and promoted engagement for the users. Engagement was more pronounced in the cCBT group; the self-administered program delivered content incrementally and perhaps was more manageable for participants. On the other hand, the format of asynchronous delivery may be cumbersome and in fact lessen engagement, a noted drawback for delivering an asynchronous text-based CBT protocol. Participants in the cCBT group noted that the program was user-friendly, a variable missing from the feedback from the eCBT group. Users in the cCBT group wrote how the 'program was . . . easy to follow' and 'how the mini-documentaries were of people in similar situations and how they dealt with it. How there were examples I could relate to and understand certain situations'. Again, this suggests that the delivery of an asynchronous text-based CBT protocol is perhaps not so user-friendly.

Design of delivery has been noted by other studies as potentially a significant element in the success of any treatment (Meyer et al., 2009). It is certainly the case that the self-administered program would far outstretch the asynchronous delivery of content in terms of multimedia and the general presentation and delivery of content and this is an important point in terms of attracting interest and maintaining the engagement of users.

Only in the cCBT group was the content of the program referenced as something that was liked: 'offered useful techniques on how to approach problems; the cognitive aspect is helpful'. Specifically, users referenced general and specific CBT strategies, for instance: 'looking at challenging automatic thoughts and inner beliefs, looking at the importance of pleasurable activities and rewards'. Users reported how the program 'introduced CBT gradually, and encourages the user to do the homework'. Some eCBT users named support and responsive feedback as something they liked, essentially referring to the feedback received from their counsellor from week to

week, for instance: 'receiving an empathetic response to my emails and knowing someone understood'. It is almost an identification of the active ingredients and definitely an identification of what participants found important in their online treatment. The weight of perception regarding the importance of both techniques and support as active ingredients reflects the differences between the two conditions and may allude to what caused change in the treatments (Richards et al., in press) – essentially, the benefits of multimedia in communicating the core elements of treatment for the cCBT group and the impact of a responsive therapist as adding value for the eCBT condition.

The medium of communication for the eCBT group was noted as a benefit: 'writing was . . . more real than talking'. This is perhaps related to a perceived benefit of the form, 'not having to talk face-to-face', that it allowed a level of distance and perceived anonymity that was seen as important. Anonymity and distance have been noted as benefits in online delivery (Efstathiou, 2009; Richards, 2009). It seemed pertinent for the eCBT group to be able to communicate with a professional and receive feedback while at the same time being at some distance and therefore providing some level of perceived anonymity. One user wrote that '[i]t is great for people who do not want to get face-to-face treatment'. Another wrote: 'was not required to talk face-to-face'. It has been suggested that such a form may be necessary for some clients who might feel too ashamed to present face-to-face, at least initially (Leibert, Archer, Munson, & York, 2006; Simpson, 2009). Writing instead of talking, and from a distance, has other noted benefits including the therapeutic benefit of writing and the potential for disinhibition (Suler, 2004; Wright, 2002; Wright & Chung, 2001). One user wrote that the benefit of writing gave 'time to think about what I was saying. I'd fill each session in over days, so I'd always be thinking about them and what to write'.

Participants in both groups identified aspects of time and pace as something they least liked about the online treatment. It appeared in the feedback in two ways, firstly when participants experienced difficulties in finding the time to complete the weekly sessions. One eCBT user commented, 'the tasks are time consuming with a lot of information to assimilate. In my case due to lack of time it was difficult to cope with this'. A cCBT user 'found it hard to get time to do all the practical work'. The program is demanding and perhaps a more flexible schedule than weekly would be more appropriate. Secondly, users disliked that deadlines were largely left up to the individual; the burden of responsibility may be too much for some. One user wrote, 'there wasn't a deadline'. Carlbring (2004) reports a similar concern that having no deadlines at all seems to have disadvantages. Considerations of time and pace have implications for optimal delivery of online treatments.

Some users in both conditions experienced the treatment program as complicated. In the eCBT group it was the case that from time to time users lacked understanding of what was being asked of them, for instance 'did not understand some of the tasks', and 'Sometimes it took me a while to get my head around what the homework was'. However, unlike the cCBT group, they could ask for clarification and this was noted: 'it was always clarified when I asked for help'. The cCBT group were more critical, mentioning that explanations were at times lacking depth and that they were sometimes unsure whether they understood what was being asked of them, for instance whether they were 'picking up the instructions correctly'. Unlike the eCBT condition, they did not have the opportunity to ask for

clarification and this absence of support is noted. Even at a practical level support may be required.

In the eCBT group the delivery mode of asynchronous counselling was found to be impersonal and restrictive, meaning users might have been less open than in a face-to-face setting: 'It is very impersonal. I don't feel as if I opened up as much as I would to a face-to-face counsellor'. Secondly, we used a generic online counsellor sign-off. One user recognised this and felt strongly about the fact 'that my counsellor had no name!!!'. There seems to be a need for personal contact throughout the program. Participants' comments highlight areas of potential weakness in delivering online treatments. Making simple changes, such as adding the counsellor's name, may have the impact of a more personal contact. Indeed, recent ethical guidelines for online counselling advocate that online counsellors should have a verifiable identity (Anthony & Goss, 2009).

Personal contact in the cCBT condition surfaces as a noted absence of some form of support throughout treatment: 'I would have found it useful to have some human contact when deciding on the projects I was to work on. . . . even an email address that I could use if I was confused or needed clarity would have been useful'. Consequently, there is a risk that a self-administered treatment could further isolate users and could aggravate symptoms: 'online treatment can only be so helpful. There's no negative consequences for not completing the tasks (save ongoing depression and anxiety of course). I feel that maybe many people who suffer from depression feel isolated from other people and an electronic counsellor cannot help this, it may even aggravate it'. The noted absence of support in helping users to make decisions at key points in the program and to understand tasks suggests that users of the self-administered program recognised the need for some support, even if only practical support.

Some users in the cCBT group also experienced frustration with having to choose between some content, for example the graded exposure and sleep management modules. There is a sense at this point that users struggled to make informed choices. One user suggests having a 'summary sheet' to help them decide. At other times there was an experience of content mismatching the needs of the user. One user wrote, 'Sometimes the program took me down a route that is not particularly relevant, for example, I was given an exercise on activity scheduling, which is not a problem for me. Sitting through this is frustrating, especially as there is no way to skip ahead'. Perhaps at times the content needs more scaffolding to support user choices, and flexibility to reject content that may be unfitting. This is a reflection of the level of responsiveness in such a self-administered program. Content mismatching did not appear as a concern for the eCBT group, but again their focus was more on the support and feedback they received alongside the benefits of communicating with someone in relative anonymity. It was therefore the case that at all times the eCBT group could consult their clinician and perhaps this again references the benefits and need for supported implementation of online treatments.

As with using technology in any field, technical issues can arise for users. Online treatments are no exception. At times users experienced difficulties in accessing treatment or printouts, or their computer stalling, all causing understandable frustration. One user documented their experience as follows: 'Technical issues, connection failures (or similar) made me have to go through the already completed parts of one session another time, a very tiring experience'. Perhaps a consideration for implementing online treatments is to have technical support available to users.

Other aspects of form that were not liked at times were 'the voice-over and the music'. Such design elements can cause frustration and potentially limit the usefulness of the program for some users. Perhaps users should be able to turn off music or change the voice-over to something more suitable. These are significant design issues that may help to improve future delivery.

The final theme that occurs for both groups is related to the number of tasks that the online treatment asks of users. There is a sense that this was experienced as somewhat overwhelming. It needs to be remembered that for the most part users also have a variety of other committments in their lives: 'I found it hard to get time to do all the homework . . .'. Students progress through different periods of heightened committments, such as exam periods, and at such times there is a need for more flexibility. More choice about the sequence of completing sessions and meeting deadlines based on a variety of external factors may yield greater adherence.

The delivery of computer-based and online treatments brings with it a host of ethical challenges that have been debated in the professional and popular literature for many years (Sampson, Kolodinsky, & Greeno, 1997). It is, however, the case that many of these issues have now been addressed adequately for the professional practice of online counselling. In particular, ethical guidelines have been developed for the practice of online counselling, professional organisations have been established to support its development, and training courses for professionals to work ethically online have evolved (Richards & Viganò, 2012).

Limitations

The main limitation of the current study was the low response rate. In total, from 80 participants who began treatment we received only 25 (eCBT: 10; cCBT: 15) end-of-treatment responses to the satisfaction measure (SAT). This could be due to the fact that dropout from treatment was high and consequently affected the research response rate. Although the group of respondents is largely representative of the entire group who begun treatment, any potential generalisations made are consequently tentative. Responses did not differ greatly between the groups on the quantitative satisfaction items, but due to low statistical power any trends that favoured one group over another in their responses were not significantly identified. While the second author evaluated the data without prior knowledge of which group the data came from, a noted limitation is the subjective nature of using a qualitative approach.

Conclusion

The current study examined participants' levels of satisfaction with their online-delivered CBT treatment. Participants were clear in their agreement that both modes of delivering the CBT protocol were viable options. Consequently participants were satisfied, found the treatment helpful and would recommend the treatment to others. It is clear that there are aspects of the delivery in both conditions that potentially enhance or detract from the treatment. The format of delivering online treatments came to the fore with the difference found between the ratings for ease of use. This was rated somewhat higher for the cCBT group. Benefits of delivering treatments online can be enhanced. For instance, both groups highlight the usefulness of having self-control over the administration of their treatment. For the eCBT group, having

support from a therapist at a distance was seen as useful. The cCBT participants further mention the learning they achieved in terms of the CBT skills and strategies and also how the treatment was user-friendly. At the same time, however, the eCBT group noted how the treatment could be complicated and impersonal, a point also noted for the cCBT group. The cCBT group also highlight that the program could at times not match what they needed, and the level of responsiveness was limited. Lastly they also highlight technical difficulties as a cause of frustration and irritation in the online treatment. Aspects of the delivery of online treatments that are identified in the satisfaction measure data need to be considered carefully and can contribute to the successful design, delivery and implementation of online treatments.

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